Killara Rehabilitation Referral Form

To be completed and faxed by CCC or NUM from referring ward after medical referral for Rehabilitation is completed or as indicated by pathway
Fax No 9540 7710 Waiting list enquiries to CCC page 383 or NUM1 page 847

Affix Patient Addressograph Label (Minimum data required correct name and MRN)		
	Date of Referral:	
	Referral completed by: (Name, designation & Sign)	
	Pt Location at time of referral:	
	Referred to: (Specify which physician and or team)	
	Current Medical Team Contacted re referral	Yes ☐ Date:

Diagnosis	
Rehabilitation Goals (Mobility, Self-care deficits etc)	
Expected LOS: ________ days	Is patient suitable for ILU at time of transfer to Rehab Yes ☐No ☐
Brief Medical & Nursing Hx	
Current Mobility	
Pre Morbid Mobility	
Current Self Care Ability	
Pre Morbid Self Care Ability (Including services)	
Current Continence (Specify Day & Night)	
Pre-Morbid Continence	
Cognitive Status	
Social Situation or supports (Lives alone or with carer)	
Expected D/C Destination	Home ☐Hostel ☐Nursing Home ☐Retirement community ☐
Additional Information (Wound care, Nutrition, speech etc)	MRSA: Yes ☐Specify

Priority for Rehabilitation		
High ☐	Medium ☐	Low ☐
Date of Referral	Date of Transfer	Date of Discharge